Southern California University of Health Sciences

- ❑ **CHIROPRACTIC**
- ❑ **ACUPUNCTURE**
- ❑ **INTEGRATED SCIENCE**
- ❑ **MASSAGE THERAPY**
- ❑ **AYURVEDA CERT**

Office of the Registrar

REQUEST FOR TRANSCRIPTS

Name: _____ Student ID#: _____ Date: _____

(IF NAME HAS CHANGED) Name as printed on diploma: _____

S.I.N./Soc Sec #: _____ - _____ - _____ Birth Date: _____ Grad Date: _____

Address: _____

Telephone: _____

Signature: _____

PLEASE SEND ( ) SET(S) OF MY TRANSCRIPT AND A COPY OF MY DIPLOMA (IF APPLICABLE) TO:

Name: _____

Attention: _____

Address: _____

City: _____ State: _____ Zip Code: _____

The fee for each official transcript: **$5.00**

Attached is: ❑ CHECK ❑ MONEY ORDER ❑ CASH In the amount of: **$** _____

PLEASE MAIL YOUR REQUEST WITH PAYMENT TO:

SCUHS
Attention: Registrar's Office
16200 East Amber Valley Drive
Whittier, CA. 90604

OR

You may fax this request **with the credit card authorization form** to:
(562) 902-3306
Attention: Registrar's Office

YOUR REQUEST WILL NOT BE PROCESSED WITHOUT VALID PROPER PAYMENT

For Use by Registrars Office:

P/U Signature: _____ Date Received: _____

Date Mailed: _____ Payment: _____ Processed By: _____

REV 09/11